Swing Bed Team Meeting
Care Plan Update

Patient:_____
Room:_____
Date: __/__/__

Services Changed: ☐ No Change
Health Conditions: ☐ No Change ☐ Improved ☐ Declined
Special Treatments and Procedures: ☐ No Change ☐ Improved ☐ Declined
Precautions: ☐ No Change ☐ Improved ☐ Declined
Medications: ☐ No Change ☐ Improved ☐ Declined
Discharge Plan: ☐ Anticipated Discharge Date: __/__/__
Discharge Needs: ☐ No Change
Cognition/Memory: ☐ No Change ☐ Improved ☐ Declined
Decision-Making: ☐ No Change ☐ Improved ☐ Declined
Mood, Behavior, Pychosocial Functioning: ☐ No Change ☐ Improved ☐ Declined
Speech/Language: ☐ No Change ☐ Improved ☐ Declined
Hearing: ☐ No Change ☐ Improved ☐ Declined
Vision: ☐ No Change ☐ Improved ☐ Declined
Physical Activity Tolerance: ☐ No Change ☐ Improved ☐ Declined
Bed Mobility: ☐ No Change ☐ Improved ☐ Declined
Transfer: ☐ No Change ☐ Improved ☐ Declined
Mobility/Device: ☐ No Change ☐ Improved ☐ Declined
Oral Status/Swallowing ☐ No Change ☐ Improved ☐ Declined

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Nutritional Status:	☐ No Change ☐ Improved ☐ Declined
Diet:	☐ No Change
Continence:	☐ No Change ☐ Improved ☐ Declined
Self Care Skills:	☐ No Change ☐ Improved ☐ Declined
Leisure Activities:	☐ No Change ☐ Improved ☐ Declined
Other:	☐ N/A

Signatures:

Patient	_____	___/___/___	_____	___/___/___
Family	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___
	_____	___/___/___	_____	___/___/___